Programme Feature

Expanding contraceptive choice in Ethiopia

John P. Skibiak, Tekle-Ab Mekbib & Haileyesus Getahun

The 1994 International Conference on Population and Development (ICPD) signalled a major paradigm shift in the field of sexual and reproductive health. It called for a more comprehensive view of human reproduction – one entailing collaboration across sectors that previously had been viewed separately. It heightened awareness of the synergy among health-care services and it highlighted the influence of cultural aspects on reproductive health needs. Today, the impact of this new perspective is evident throughout the reproductive health field. But nowhere has it forced a more profound reassessment of assumptions and practices than in the field of contraceptive introduction. Whereas contraceptive technologies and their service delivery correlates were once accepted as an independent area of inquiry, today, they are viewed as part of a broader system – one that includes users' needs as well as the capacity of the health-care system to introduce technologies with appropriate quality of care. No longer can it be taken as an act of faith that the introduction of a new contraceptive technology will necessarily enhance choice or respond to some unmet need.

Since the mid-1980s, the Population Council has tested and introduced a number of new contraceptive methods, including Norplant and the Copper T380A intrauterine device (IUD), both of which were developed by the Council's Centre for Biomedical Research. But even by 1994, the Council had already taken important steps in approaching contraceptive introduction from a reproductive health perspective. Judith Bruce's seminal work on quality of care, for example, explored the relationship between such concepts as "choice" and "availability of methods", emphasising that the two need not necessarily be synonymous. Soon thereafter, the Council renamed its "Contraceptive Introduction Programme", adopting the more comprehensive, user-focused title, "Programme to Expand Contraceptive Choice" (ECC).

Another important step in adopting a more reproductive health perspective, was the ECC Programme's collaboration with WHO in the development and implementation of what has since come to be known as the WHO Strategic Approach – a three-stage approach to expanding contraceptive choice and improving the quality of reproductive health services. In this approach, contraceptive introduction is seen not just as the resolution of "technology" issues, but the articulation of three interrelated components: technologies, users' needs and the service delivery system. For almost a decade, this strategic framework has been applied to guide the introduction of new technologies worldwide.

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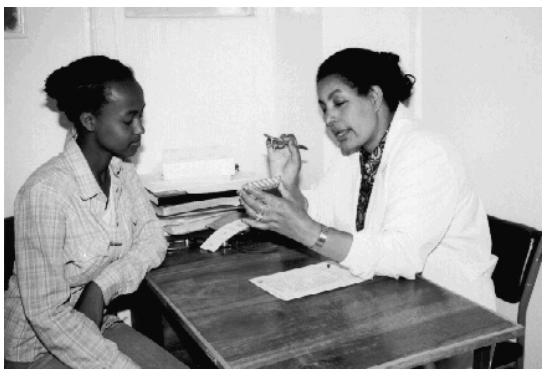
In 1998, the Ethiopian Ministry of Health decided to adopt the WHO Strategic Approach, beginning with the implementation of a nationwide assessment of reproductive health needs. The Assessment was broad in scope – covering topics as diverse as gender equity, health-care management, quality of care, contraceptive method mix and adolescent reproductive health. One unexpected finding to emerge from the assessment was the discrepancy between, on the one hand, young people's familiarity with modern contraception, and on the other, the high levels of unwanted pregnancy and unsafe abortion experienced by them.



The project has trained staff in the delivery of youth-friendly services

To account for this discrepancy, the assessment explored such issues as unsympathetic providers, lack of privacy and limited service delivery outlets. A novel possibility, however, one suggested by young people themselves, was the lack of contraceptive methods – even at so-called youth-friendly facilities – that matched the features of their sexual behaviour: that it is irregular, unplanned, hurried and clandestine.

Improving access to coital-dependant methods

In 2001, the Family Guidance Association of Ethiopia (FGAE), the leading provider of reproductive health services to young people, requested ECC Programme assistance in exploring the impact of expanding access to methods that young people said they wanted. These included existing coital-dependant methods (CDMs), such as the male condom, vaginal foaming tablets, as well as newer methods such as the female condom and emergency contraception. The two-year operations study hopes to use the introduction of these methods to strengthen the quality of youth-centred services. It plans to achieve this by enhancing provider and client knowledge about contraceptive and family planning options; by assuring adequate contraceptive stocks at participating health-care facilities; and by breaking down the barriers that impede access to CDMs as well as longer-term methods. Most importantly, the study hopes to maximise the potential role of CDMs – either individually or as dual protection – at reducing the risk of both HIV/STI transmission and unwanted pregnancy.

The study design divides FGAE's national network of eight youth centres into an experimental group – with interventions focusing on expanding choice and strengthening quality of care – and a control group. The groups will be closely monitored to understand 1) the ability of CDMs to address unmet needs of young people; 2) the impact of addressing such needs on other aspects of reproductive health behaviour; and 3) the challenges associated with introducing CDMs.

So far, project staff have established new tools and procedures for collecting and monitoring service statistics; they have trained staff in the delivery of youth-friendly

services; they have begun developing IEC materials; and they have completed two critical surveys.

Improving performance of youth centre staff

Early visits to the eight project sites found so much variability in the performance of local peer providers that the introduction of new methods alone would have little impact, unless the staff performance could be improved considerably. Consequently, the project sent self-administered questionnaires to all FGAE youth peer providers. The results showed that the successful functioning of peer providers was positively related to their selection by neighbourhood associations (vs. the youth centre) and inversely related to their dependence on the youth centre for remuneration/rewards and their length of time in the position. FGAE management now applies these results in the recruitment of new peer counsellors.

Emergency contraception

The second survey was the baseline for comparing post-intervention impacts. The population-based survey included a sample of 3280 young people (10-24 years) and 1053 health-care providers from the communities served by each of the centres. The survey highlighted the limited familiarity of Ethiopia's health-care providers with emergency contraception (EC) – a key CDM to be introduced through this study. Though most providers were aware that oral contraceptives could be used for emergency purposes, accurate knowledge of pill type, correct dosage, and timing of administration was relatively low. Few had ever actually administered EC, while half felt that its use could lead to promiscuity.

HIV/AIDS and dual protection

As elsewhere in sub-Saharan Africa, young Ethiopians remain especially vulnerable to HIV/AIDS. More tolerant of risk, resource-poor, and sexually active, women and men between the ages of 15 and 24 make up a sizeable proportion of new HIV cases in the country. Though the FGAE study seeks to strengthen the availability of CDMs, project staff are acutely aware that only one such method actually offers protection from STIs. For that reason, all project print materials, product packaging and communication strategies emphasise one message – that condoms come first. EC, for example, is presented – not as a method choice, per se – but as a back-up in case of condom breakage or rape. But the study has gone one step further, by putting into place for the first time, MIS and service statistics systems that make it possible to track and quantify the actual use of dual protection by youth centre clients.

Preliminary results from the FGAE study clearly demonstrate the multifaceted, multisectoral nature of expanding contraceptive choice within a broad reproductive health context. CDMs do indeed respond to the needs and unique circumstances facing young people. But they also call for major adjustments in the way reproductive health services are provided, information is disseminated, and data is collected. ❖

John P. Skibiak, Regional Office for East and Southern Africa, Population Council, P.O. Box 17643, 00500 Nairobi, Kenya; Tel: +254-2-71.34.80; Fax: +254-2-71.34.79; e-mail: jskibiak@popcouncil.or.ke; Tekle-Ab Mekbib, Population Council, Ethiopia; P.O. Box 33998, Addis Ababa, Ethiopia; Tel: +251-1-52.65.74; Fax: +251-1-52.65.77; e-mail mekbibt@telecom.net.et; and Haileyesus Getahun, CDMs Project, FGAE, P.O. Box 14023, Addis Ababa, Ethiopia; Tel: +251-1-63.28.52; Fax: +251-1-63.28.50; e-mail: haileyesusg@yahoo.com

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Programme Feature

Men as partners in reproductive health

Lissette C. Bernal Verbel & Manisha P. Mehta

Most reproductive health and family planning programmes focus on serving the needs of women. However, practitioners have realised that focusing primarily on women – and neglecting men and their reproductive health needs – is not an effective strategy and may have negative consequences, especially in the context of HIV/AIDS. EngenderHealth's Men As Partners (MAP) programme aims to place the needs of men – as women's partners and as individuals – on the agenda of health-care providers worldwide.

Men as partners

Studies have shown that constructive male involvement in reproductive health results in better reproductive health outcomes for both men, women and their families. A study in the United States illustrated that men who are educated about reproductive health issues are more likely to support their partners in contraceptive use, use contraception themselves, and demonstrate greater responsibility for the children they father. In India, involving men in antenatal education resulted in better perinatal care and lower perinatal mortality. In Ecuador, a study demonstrated that 89% of women wanted their partner to accompany them on their next family planning appointment and 94% would have liked their partner to be present during their family planning counselling session.

EngenderHealth – formerly AVSC International – aims to play a leading role in the global effort to implement the Cairo mandate to increase men's access to services and information – without detracting from the resources committed to women's health. Its "Men As Partners" (MAP) programme, launched in 1996, is rooted in the knowledge that genuine social change depends on male involvement with reproductive health issues. A critical component of the programme is the belief that educating men about their own health as well as that of their partner can contribute to positive health outcomes for both. To this end, MAP seeks to increase access to information and services through evidence-based strategies, that improve men's sexual and reproductive health, and promote the constructive role that men can play in family planning, maternal care and HIV prevention in their families and communities.

Through research, workshops and on-site technical assistance, MAP aims to achieve four main goals:

- ❖ increase men's awareness of, and support for their partners' family planning and reproductive health choices
- ❖ increase men's awareness of the need to safeguard